Remarks by Cong. Henry A. Waxman
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Opening remarks: the problems we face

Good morning. It's a pleasure to be here with you today here in Pasadena. It's always a pleasure to be out here in the California sunshine.

And frankly–I know this won't surprise you--it's a pleasure to be out of Washington. If you're a Democrat, as I am, this is not a pleasant time. But whatever your party, if you care about health care, this past Congress has not been a good one. It has been typified not by what we did do, but what we failed to do. And when this country has as many problems in health care as it does, that is truly an inexcusable result.

Let's just review some of the problems we've got:

**we've got 41 million uninsured Americans, and the problem seems again to be getting worse.

In California, we've got one of the highest rates of uninsured people–and the most without employer-sponsored coverage. Since in many ways the California economy is the model for the future, it signals the kinds of problems we are going to see increasingly in a service-oriented economy.

**we've got a Medicare population of seniors and disabled people over a third of whom don't have any coverage for prescription drugs, and don't have any source of coverage available, and many of the rest have their coverage eroding. This is the population that is oldest and sickest, the population with chronic conditions and disabilities. This is the population that needs and uses the most prescription drugs.

But it's also the population that faces the most price discrimination. They don't get the advantage that insurers and HMOs negotiate for themselves. They don't get the lower prices that pharmaceutical companies sell their drugs for over the borders in Canada and Mexico, or in Europe.

This isn't a service that's a luxury. Prescription drugs are basic to good medical care. But we can't seem to find the will or the way to provide people access to the benefit they need.

**we've got a Medicare program that has over the past five years consistently skimped on reimbursement. Ever since the so-called Balanced Budget Amendments of 1997, when cuts in Medicare were made essentially to balance the budget, we've not exactly starved the program, but we've certainly put it on a strict diet.

That might not be so bad if all the providers and HMOs were fat; but those days are long gone in our health care system.

**we've got shortages of nurses, and that can't continue without compromising care in our hospitals and even more certainly, in our nursing homes.

We've got trauma care systems that are underfunded and closing.

We've got a hospital and nursing home industry that is increasingly struggling to get capital–as you all know.

**we've got a consumer rebellion against managed care–or at least tightly run managed care. But we've got increasing health care costs again, and no obvious tool in our arsenal to attack them.

**and we've got a trend toward cashing out health insurance coverage, so that the individual supposedly manages more of their care. It sounds good in theory, but it really means more deductibles, more cost sharing, more setting the individual consumer loose to try to manage the health care market by themselves.

Whether we call them consumer directed health plans or Medical Savings Accounts, we're moving to a system that works very well for people who are basically healthy and wealthy enough to cover unexpected costs, but not for sicker and older and poorer people with chronic needs and high costs.

**we've got States that are struggling under the costs of Medicaid. Most of us forget it, but the reason those costs are so high is that States spend most of their dollars on elderly and disabled patients.

They pay about 50% of <u>all</u> nursing home care in the country. They are the only public financing program that pays for prescription drugs–and they pay for a lot of them: for people who are HIV positive, for elderly people with chronic conditions, for severely disabled persons with mental and physical illnesses.

**we've got local areas which can't sustain their health care systems. Los Angeles County, which I represent, is one area that is in danger of being forced to close substantial portions of its public hospital and clinic system because there are too many uninsured, and not enough revenue to support it.

**we've got a crumbling public health infrastructure. It took a terrorist attack to make the public aware of how very vulnerable we are. We've got threats of small pox and anthrax, and an outmoded system to try to track, identify and deal with them.

So that's the problems we're facing. They are problems that cry out for solution.

Why is action so difficult to achieve:

So why haven't we been more successful, why can't we pass legislation to solve these critical problems? That's not an easy question to answer.

But I think there's some basic factors we have to ponder.

First, and this might seem a strange thing to put at the top of the list, health care is a big business. Nobody knows that better than you all. There's billions of dollars involved. Every reimbursement decision we make, every coverage decision, every drug and device approval–they all have major financial effects on companies, investors, jobs in communities.

Further, the very magnitude of the dollars involved make finding solutions difficult. Nowhere is this better demonstrated than trying to find a way to solve the problem of the uninsured.

I've been in Congress since the mid-70s, and we've tried over and over to find a way to assure that all Americans have health care coverage. There has been variety in the approaches, but there has always been one constant: it costs a lot to do. It costs a lot if you're using private coverage; it costs a lot if it's public coverage. And every year, it costs more, billions and billions more just to try to get to the same goal.

Additionally, whether we are talking about programs we've already got–like Medicare, or talking about new ways to cover the uninsured, since we are always dealing with a limited pot of money, we've got one interest pitted against another.
It might not be a zero-sum game, but it is close to it.

And since recently enacted tax cuts have been large–and adopted without consideration of the consequences in terms of leaving available resources to solve other problems–the pot of money available to deal with health care problems has been severely constricted.

Let's look at what just went on–or didn't go on, as the case may be–in the Congress that just concluded last week.

We started out with two very big issues on the agenda–and interestingly enough, neither one had to do with covering the uninsured. One was adding a prescription drug benefit to Medicare, and the other was providing funds to Medicare providers to mitigate the continuing effects of the cuts that were put in law in the 1997 Balanced Budget amendments.

First, those two goals were in competition, or at least that's the way they were defined. Democrats tried but failed to salvage some of the budget surplus for a drug benefit and other health needs, but the tax cut took it all, and then some. So the health care programs ended up competing with each other for an almost nonexistent pot of dollars.

That was particularly difficult because of the expense of the drug benefit itself. Even with a limited benefit and optimistic assumptions about the ability of PBMs (pharmacy benefit managers for those of you who aren't familiar with the lingo) to hold down costs, even the Republican program was estimated to cost almost $300 billion over 10 years.

And that was for a plan that had no assurance the benefit would be decent enough to actually attract participation by the elderly, because their out-of-pocket costs in terms of premiums and responsibility for uncovered benefits remained so high.

If you don't get wide participation, you get adverse selection–only the people who know they'll be high users think the cost is worth it. That destabilizes the system, and it breaks down.

Now the average person listening to this instinctively thinks: "wait a minute. $300 billion is an awful lot of money." And indeed it is. But let's think about the problem.

The elderly currently are estimated to spend one-and-a half *trillion dollars* over 10 years on prescription drugs. So providing a $300 billion Medicare benefit is picking up only about 20% of the expenditures. Look at it another way. To provide a Medicare benefit that is similar to what Federal employees have–and that's about what most decent employer plans cover–that would cost over $750 billion over 10 years.

Trying to find that kind of money in a budget already in deficit largely because of the tax cuts and the deteriorating economy is extremely difficult, to say the least.

Then let's look at something that seems fiscally more within reach--providing additional funds to Medicare providers to help mitigate the effects of the cut-backs from 1997. That became a victim of inaction as well.

First, as inevitably happens, when a so-called Medicare give-back bill is on the table, virtually every provider comes in asking for money. When the word gets out that doctors or hospitals or whichever is likely to get some fiscal relief, every body else wants to get on the train.

So the size of the package inevitably grows. Acting on any one piece, or just a few, means others get left out. So groups often try to block any more limited action that would deal with one provider's issue and leave out others.

We just saw that play out in the effort to keep Medicare's physicians' fees from actually being reduced for two years in a row.

Everyone agreed this would have very undesirable consequences. Everyone knew we were risking compromising access for many Medicare beneficiaries. Yet trying to deal with just this one problem, but leaving others out, proved to be impossible.

Picking up the whole package of provider give-backs might have been another approach. But the Administration refused to support that unless it was paid for through other program reductions. That wasn't possible.

Further the consumer groups, led by the AARP, opposed action dealing with provider issues if the ultimate consumer issue–prescription drug coverage–was left behind.

The end result was stalemate.

The Future

So the question is, what can we expect in the future.

That of course is an extremely cloudy picture. But there are some obvious factors to think about.

One is that for the first time in many, many years, we have Republicans in control in the White House, the House and the Senate. While we technically had that at the very beginning of this Administration, before Senator Jeffords aligned himself with the Democrats, in fact the Administration was so new then, that we really have had no experience with how this situation will play out.

Second, we also know that nominal control of both Houses does not give free rein to one party. The Senate is designed to give the minority party a great deal of control. So while the ability to control the agenda will certainly help our Republican colleagues to achieve changes that failed in the last Congress, if they overreach, they will find many of their initiatives blocked.

Third, we know something else: we face a situation of very large and growing deficits: the Congressional Budget Office projects deficits of over $200 billion a year into the foreseeable future. When the tax cut is made permanent–as it surely will be, since this is a top priority for the majority–the situation will only be worse.

And we know from experience that deficits have inevitably resulted in spending cuts. For Medicare, and probably Medicaid too, we almost certainly will face reconciliation bills that will require billions of dollars of cuts in these programs.

Despite the fact that we should have learned our lesson when we made large cuts in Medicare in the Balanced Budget Amendments of 1997, we almost certainly will return to a period when we will be reducing rather than adding to reimbursement levels in these programs.

Additionally we know that the philosophic approach of the Republicans to Medicare is to turn it more into a private insurance program, and to provide beneficiaries with a defined contribution–some would call it a voucher–to buy in the private market.

From the point of view of the provider community, that will not necessarily be good news. In fact, I believe it will mean less accountability and less responsiveness to the fiscal problems providers will face. With an insurer or an HMO standing between the government and the provider, making the reimbursement decisions, it will be much harder for the Congress to protect their community providers; in fact, it provides a ready-made excuse to wash their hands of the responsibility of dealing with the consequences.

Of course, the public Medicare program will not disappear. But putting it in competition with private plans, with all the problems we know occur in the insurance market of cherry picking better risks, and with the natural inclination of older and sicker beneficiaries to stay with the program they know, it seems to me we will not have a level playing field. The public Medicare program will inevitably be put in a fiscal squeeze that will starve the program.

Further, the private competitors will not carry the burden that Medicare has of providing extra resources to what we might call "public good" entities: teaching hospitals and trauma systems and disproportionate share facilities.

Similarly, we know that Medicaid, which already is struggling with inadequate Federal contributions, will be at the short end of the Republican stick in terms of funds. I fully anticipate another run by my Republican colleagues to cap the level of Federal support for this program.

We know the carrot that the Feds will hold out to the States will be greater flexibility: that is a code for no requirements in terms of who is covered, no limits on cost sharing even for the very poor, no requirements for the services that must be paid for, and no standards for adequate reimbursement.

If providers think they struggle now with Medicaid reimbursement levels, they can anticipate that it will only get worse when Federal support dwindles and all pretense of Federal standards is gone.

We also know that two other areas have been outlined as priorities for action, at least by the Speaker of the House. Those are prescription drugs for the Medicare population, and covering the uninsured.

Nobody can argue with those priorities. We never have. But the "solutions" that my colleagues will offer is another matter.

Put bluntly, I don't think they will work.

Their approach to covering the uninsured is based on tax credits. But cutting support for public programs that do provide coverage, while establishing a series of tax credits to cover the uninsured, will, I fear add to rather than solve the problem.

First, designing a tax credit that doesn't result in an even faster erosion of employer sponsored coverage is difficult.

Providing a tax credit that's large enough to really make coverage affordable for low and moderate income people is expensive. And inevitably, a lot of the dollars will go to people who already have coverage: now they will get a subsidy. That's not necessarily bad: treating them equitably with people who have employer sponsored coverage is admirable policy. But it spends a lot of scarce dollars on people who are already insured.

Further, the tax credits my Republican colleagues envisage necessarily rely on the individual insurance market. That is a market that is expensive and discriminatory. Making it work is probably impossible, but it certainly can't be done without a level of regulation that it is clearly anathema to the very people who are so enamored of tax credits.

A basic rule in health care has always been: first, do no harm. I fear a large system of tax credits will do exactly that. It might be an experiment worth trying if we had money to burn, and if we could be sure that the result would not be erosion of employer-sponsored and public program coverage. But both of those seem the inevitable result.

Finally, I think we have a very clear indication of where our Republican colleagues want to go in terms of providing drugs for seniors. We saw it in the bill that passed the House.

They don't want drugs as a regular benefit in Medicare. They do want to have people get their drug coverage through private plans providing that single benefit.

It is doubtful it will be affordable or meet the needs of the senior population. When this idea was initially put forward by my Republican colleagues, the private insurers were among the first to declare that it wouldn't work. Single benefit plans, particularly where the insurers can't control the development of new drugs and the prices, were likely to self destruct.

The eleventh hour conversion of the insurers in support of the plan smacked less of actually changing their mind than of deciding their good relations with the majority, who held their fate on so many other issues in their hands, took priority.

The concept that competition among these plans, and negotiations with the drug companies to treat their drugs as favored drugs, would solve the cost problem in the prescription drug area is optimistic at best, and likely to be wrong.

It would be much more effective to stop the game-playing and get generic drugs on the market faster, or to stop discriminatory pricing by the drug companies that benefit their overseas markets at the expense of the American consumer. But the Administration has shown little interest in legislation in that arena.

Further, it will be interesting to see if the Republicans continue to propose spending at the same level for a drug benefit now that they have to face the possibility that it might become law.

First, because of the ever-increasing costs of drugs, it will already cost them considerably more in the next Congress than in this one to provide the very same benefit, ill-defined as it was in their legislative package.

It was already inadequate. Further reduction will make it even more of a false promise.

It should be noted that Republican leaders in the Senate are already talking about a drug benefit for low-income seniors only. So we may see a turn in that direction.

Conclusion

In conclusion, I would just say this.

We've got serious problems in health care. We have millions without coverage, and health care providers that are in trouble. And costs are going up.

We've got a large deficit which makes it more likely we'll be cutting rather than adding to programs.

And we've got an Administration and a congressional majority that may be more concerned that their responses to these problems are consistent with their ideology than effective at solving the problems.

They think they've got the answers. I think those answers will result in some unfortunate affects on the system we've got.

In any case, we're about to find out.